No. 300
10-48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25930

FILED JUL 28 1953

BIRTH NO. _____ REG. DIST. NO. 291 PRIMARY REG. DIST. NO. 5991 Registrar's No. 47

1. PLACE OF DEATH
a. COUNTY Putnam Com
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Liberty Tp
c. LENGTH OF STAY (in this place) Lifc
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Livonia, Mo.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo
b. COUNTY Putnam
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Liberty Tp.
d. STREET ADDRESS (If rural, give location) Livonia, Mo 0860 0

3. NAME OF DECEASED (Type or Print) a. (First) Jessie b. (Middle) Margareth c. (Last) Anderson

4. DATE OF DEATH (Month) July (Day) 1 (Year) 53

5. SEX F
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M
8. DATE OF BIRTH Mar 28, 1876
9. AGE (In years last birthday) 75 | IF UNDER 1 YEAR Months 3 Days 3 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work
10b. KIND OF BUSINESS OR INDUSTRY self
11. BIRTHPLACE (City and State or Foreign Country) Putnam Co Mo. 0
12. CITIZEN OF WHAT COUNTRY? US.

13a. FATHER'S NAME Anthey Wickless
13b. MOTHER'S MAIDEN NAME Elizabeth Attsincer
14. NAME OF HUSBAND OR WIFE Richard Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME Finnis Anderson Queen City ADDRESS Mo

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Degeneration

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility
DUE TO (c) High blood Pressure

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 443 X
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1952, *to* June 29, 1953, *that I last saw the deceased alive on* June 29, 1953, *and that death occurred at* 3 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE R.E. Vaughn (Degree or title) D.O.
23b. ADDRESS Lancaster Mo
23c. DATE SIGNED 7/2/53

24a. BURIAL, CREMATION, REMOVAL (Specify) B
24b. DATE July 3, 1953
24c. NAME OF CEMETERY OR CREMATORY St Johns Cem
24d. LOCATION (City, town, or county) (State) Livonia Mo

DATE REC'D BY LOCAL REG. 7-25-53
REGISTRAR'S SIGNATURE Marvell Durbin 266 0
25. FUNERAL DIRECTOR'S SIGNATURE F O Husted Son ADDRESS Unionville Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____ Student Embalmer No. _____ working under my personal supervision.

Student .....
Student Embalmer

Signed Muel E Husted

Licensed Embalmer No. 3304

P. O. Address Unionville, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.